MEDI-CAL PHYSICIAN APPLICATION/AGREEMENT

IMPORTANT

- Read Instructions before completing the application
- Type or Print clearly and sign in blue ink

Return Completed Forms To:
Department of Health Services
Provider Master File Unit
714 P Street, Room 950
P.O. Box 942732
Sacramento, CA 94234-7320
(916) 323-1945

FOR STATE USE ONLY:

Enrollment Action Requested: **Date:** _____

- ❑ Enrollment
- ❑ Request for Continued Enrollment:
  - ■ Current Provider Number: _____
- ❑ Add Rendering Provider:
  - ❑ Add Rendering Provider to a Provider Group Applicant. Group Name: _____
  - ❑ Add Rendering Provider to an Existing Provider Group. Specify Group Provider Number: _____
- ❑ Delete as a Rendering Provider in a Provider Group. Specify Group Provider Number: _____

1. Legal Name of Applicant or Provider:

_____
(last) (first) (middle)

2. Business Name:

3. Business Telephone Number:

(_____) _____
(area code) (number)

4. Business Address:

_____ _____ _____ _____ _____
(street) (city) (county) (state) (9-digit Ziip Code)

5. Pay To Address:

_____ _____ _____ _____
(street) (city) (state) (9-digit Zip Code)

6. Mailing Address:

_____ _____ _____ _____
(street) (city) (state) (9-digit Zip Code)

7. Tax Identification Number (attach copy of the Department of Treasury Internal Revenue Service Form):

___ ___ - ___ ___ ___ ___ ___ ___

8. Social Security Number (If Sole Proprietor not using a Tax Identification Number – you must attach copy):

___ ___ ___ - ___ ___ - ___ ___ ___ ___

Name of Sole Proprietor:

_____
last first middle

9. Clinical Laboratory Improvement Amendment (CLIA) Certificate Number (attach copy):

State Laboratory License/Registration Number:

10. Medicare Billing Number:

11. Gender: ❑ Male ❑ Female

12. Date of Birth:

13. List Specialty(ies):

14. Driver's License or State Issued Identification Card Number and state of issuance (attach copy):

FOR STATE USE ONLY

Status Code: _____
Effective Date: _____
PSRO: _____
County Code: _____
Provider Type: _____
Type Practice: _____
Out-of-State IND: _____
Group IND: _____
Lab IND: _____
Effective Date: _____
COS: _____
Begin Date: _____
End Date: _____
Specialty Code: _____
Operator ID: _____
Date Provider Added: _____
EPSDT: _____
Authorization Number: _____
Reviewed By: _____
Verified By: _____

Applicant Name:	Date:

15. License Number(s) (attach copy):	16. License Effective Date(s):	17. License Expiration Date(s):
18. Fictitious Name Permit Number (attach copy):	19. Fictitious Name Permit Issue Date:	20. Fictitious Name Permit Expiration Date:

21. Self-Certification and Statement of Intent to Employ a Separate Billing Method for Hospital/Clinic-Based physicians **(To be completed only if practice location is a licensed facility):**

If you are not facility based, initial here: _____.

The undersigned hospital/clinic and physician agree to the following requirement for the issuance of a Medi-Cal provider number to the hospital/clinic-based physician.

It is agreed and understood by:

_____ and _____
Physician Hospital/Clinic

That there shall be no duplicate billing for inpatient services rendered to Medi-Cal beneficiaries. All billing for inpatient services provided by the physician to Medi-Cal beneficiaries shall be billed using the physician's provider number.

To ensure the money paid to the physician is not included in the cost settlement process, we recommend that the hospital/clinic set up a separate nonreimbursable cost center to account for all clinic-related payments. Additionally, the hospital/clinic should keep track of overhead support costs related to the reimbursable costs. At year end, the costs related to the guarantee to the physician's clinical billings should be easily identifiable by our Audits staff on your cost report. If it appears impossible/impractical for you to set up a separate cost center, then the direct cost related to physician clinical activities at a minimum should be eliminated from the trial balance cost via an A-8 adjustment on your cost report.

This method of billing will become effective for services performed on or after _____.
Date

We declare under penalty of perjury under the laws of the state of California that the forgoing information is true and correct to the best of our knowledge.

Hospital/Clinic Name:			
Address:	City:	State:	Zip Code:

Authorized Hospital/Clinic Representative:

Name:	Title:
Signature (blue ink only):	

Physician Name:	Business Name (if applicable):
Physician Signature (blue ink only):	Date:

Information on Individual Signing this Application:

22. Printed Name of Individual Signing this Application:

_____
(last) (first) (middle)

23. Driver's License or State Issued Identification Number and State of issuance (provide copy):	24. Social Security Number (provide copy): ___ ___ ___ - ___ ___ - ___ ___ ___ ___ (Provision of the Social Security Number is optional)

Applicant Name:	Date:

25. Date of Birth:	26. Gender: ❑ Male ❑ Female

27. I declare under penalty of perjury under the laws of the state of California that the foregoing information and all attachments are true, accurate, and complete to the best of my knowledge and belief. I declare that I have the authority to legally bind the applicant or provider. I understand that incorrect or inaccurate information may affect my eligibility to receive Medi-Cal reimbursement and that I must report changes in the above information to the Department of Health Services, Provider Master File Unit. I hereby further declare that I will abide by all Medi-Cal laws and regulations and the Medi-Cal Program policies and procedures as published in the Medi-Cal Provider Manual. I understand that it is my responsibility to read the manual and its updates.

Signature of the person authorized to bind the Applicant or provider: _____

Title: _____

Executed at

_____ (city), _____ (state), on _____ (date).

Privacy Statement
(Civil Code Section 1798 et seq.)

All information requested by the application, the disclosure statement and the provider agreement is mandatory with the exception of the social security number for any person other than the person or entity for whom an IRS Form 1099 must be provided by the department pursuant to 26 USC 6041. This information is required by the Department of Health Services, Payment Systems Division, by the authority of Welfare and Institutions Code section 14043.2(a) and Title 22, California Code of Regulations, section 51536. The consequences of not supplying the mandatory information requested are denial of enrollment as a Medi-Cal provider and issuance of the Medi-Cal provider number or denial of continued enrollment as a provider and the deactivation of all Medi-Cal provider numbers used by the provider to obtain reimbursement from the Medi-Cal program. The consequence of not supplying the voluntary social security number information requested is delay in the application process while other documentation is used to verify the information supplied. Any information provided will be used to verify eligibility to participate as a provider in the Medi-Cal program. Any information may also be provided to the State Controller's Office, the California Department of Justice, the Department of Consumer Affairs, the Department of Corporations, or other state or local agencies as appropriate, fiscal intermediaries, managed care plans, the Federal Bureau of Investigation, the Internal Revenue Service, Medicare fiscal intermediaries, Health Care Financing Administration, Office of the Inspector General, and Medicaid and licensing programs in other states. For more information or access to records containing your personal information maintained by this agency, contact the Chief, Payment Systems Division, 714 P Street, Room 950, Sacramento, CA 95814, (916) 323-1945.

INSTRUCTIONS FOR COMPLETION OF MEDI-CAL PHYSICIAN APPLICATION/AGREEMENT

This form is an application/agreement for enrollment or continued enrollment as a provider in the Medi-Cal program. Applicants and providers may also need to provide additional information and documentation and may be subject to an onsite inspection prior to enrollment. Applicants and providers may be subject to unannounced visits prior to enrollment or approval for continued enrollment in the program. In addition to the application/agreement, the attached disclosure statement is also required for enrollment or continued enrollment.

Omission of any information or documentation on this form or the failure to sign any of these documents may result in any of the actions identified in Title 22, California Code of Regulations, Section 51000.50.

Enter the date in the space provided.

Enrollment Action Requested (Check One):

Enrollment means the applicant is not currently enrolled with the Medi-Cal program and would like to have a Medi-Cal provider number issued.

Request for Continued Enrollment means the provider is currently enrolled in the Medi-Cal program and would like to continue participation. Provide the provider number that you would like to continue to use.

Add Rendering Provider means to add a rendering provider to a Provider Group Applicant or an existing Provider Group. If this is a request to be added as a rendering provider to a Provider Group Applicant, provide the Provider Group name. If this is a request to be added as a rendering provider to an existing Provider Group, provide that Provider Group provider number.

Delete as a Rendering Provider in a Provider Group means you no longer wish to be enrolled as a rendering provider in a Provider Group. Specify the Provider Group Number.

1. Legal Name of Applicant or Provider is the first, middle and last name of the individual applying for enrollment or continued enrollment in the Medi-Cal program.
2. Business Name means the legal name listed with the Internal Revenue Service (IRS).
3. Business Telephone means the primary business telephone number used at the business location. A beeper number, answering service, pager, facsimile machine, cellular phone, biller or billing service, or answering machine shall not be used as the primary business telephone.

4. Business Address means the actual business location including the street name and number, room or suite number or letter, city, county, state, and 9-digit zip code. A post office box or commercial box is not acceptable.
5. "Pay To Address" means the address to which payment will be mailed. The Pay To address should include, as applicable, the post office box number, street number and name, room or suite number or letter, city, state, and 9-digit zip code.
6. Mailing address is where the applicant or provider wishes to receive general Medi-Cal correspondence. General Medi-Cal correspondence includes bulletin updates and Provider Manual updates. Provide, as applicable, the post office box number, street number and name, room or suite number or letter, city, state, and 9-digit zip code.
7. List the Tax Identification Number (TIN) issued by the Internal Revenue Service (IRS) under the name of the applicant or provider. Attach a clearly legible copy of the IRS Form 941, Form 8109-C, Form 147-C, Form SS-4 (confirmation notification), or Form 2363.
8. If the business is a sole proprietorship not using a Tax Identification Number, provide the social security number of the sole proprietor. Provide the sole proprietor's name. Provide a clearly legible copy of the social security card.
9. Insert the Clinical Laboratory Improvement Amendment (CLIA) certificate number. Attach a clear legible copy of the CLIA certificate. Provide the State Laboratory License/Registration Number. If this does not apply to you, enter "N/A."
10. Insert the applicant's Medicare Billing Number. If the applicant or provider is rendering in a group, the Medicare billing number will be placed on the group file. If, in the future, the applicant or provider leaves the group, it is the applicant or provider's responsibility to notify the Department to remove that Medicare billing number from the group file.
11. List the gender of the applicant.
12. List the date of birth of the applicant.
13. List the specialty(ies) (e.g. Acupuncture, Allergy, Anesthesiology, Aviation, Cardiovascular Disease, Clinic – Mixed Specialty, Dermatology, Emergency Medicine, Endocrinology, Family Practice, Gastroenterology, General Practice/Medicine, General Surgery, Geriatrics, Gynecology, Hand Surgery, Hematology, Oncology, Infectious Disease, Internal Medicine, Manipulative Therapy, Neoplastic Diseases, Nephrology, Neurological Surgery, Neurology, Neurology [child], Nuclear Medicine, Obstetrics, Obstetrics-Gynecology Neonatal, Ophthalmology, Otolaryngology, Orthopedic Surgery, Otology, Laryngology, Rhinology, Pathology, Pathologic Anatomy; Clinical Pathology, Pathology [Forensic], Pediatric Allergy, Pediatric Cardiology, Pediatrics, Peripheral Vascular Disease, Pharmacology, Physical Medicine & Rehabilitation, Plastic Surgery, Proctology, Psychiatry, Psychiatry [child], Psychiatry Neurology, Public Health, Pulmonary Disease, Radiation Therapy, Radiology, Rheumatology, Roentgenology, Surgery [head and neck], Surgery [pediatric], Surgery [traumatic], Thoracic Surgery, Urology, Urologic Surgery). If the applicant is not a physician, write "N/A" on the line.
14. Provide the Driver's License or State Issued Identification Number and state of issuance of the applicant. Attach a clearly legible copy with the application.

■ Write the applicant name and date at the top of page 2.

15. Provide the license number(s) of the applicant or provider. Attach a clear legible copy of the license.
16. List the effective date(s) of the license(s) in number 15.
17. List the expiration date(s) of the license(s) listed in number 15.
18. If the name in number 2 is a Fictitious Business Name, provide the Fictitious Name Permit Number. Attach a clearly legible copy of the Fictitious Name Permit with the application. If non-applicable, write "N/A."
19. Provide the issue date of the Fictitious Name Permit.
20. Provide the expiration date of the Fictitious Name Permit.
21. Complete the self-certification statement of intent to employ a separate billing method for hospital/clinic based physicians. If this section is applicable please read and complete the requested information. The signature of an authorized representative of the hospital/clinic is required indicating they have read, understand and agree to the items in this section. If this application is for an applicant or provider enrolling in a group, then he or she does not need to complete this question and should initial in the space provided.
22. Name of individual signing the application means the first, middle, and last name of any individual acting on behalf of and with the authority to legally bind the applicant or provider when applying to the Department for enrollment or continued enrollment as a provider in the Medi-Cal program.
23. Provide the Driver's License or State Issued Identification Number and state of issuance of the individual named in number 22. Attach a clearly legible copy with the application.
24. Provide the Social Security Number of the individual listed in number 22. Attach a clearly legible copy of the social security card with the application. Provision of the Social Security Number is optional.

■ Write the name of the applicant and the date at the top of page 3.

25. List the date of birth of the individual in number 22.
26. List the gender of the individual in number 22.
27. An original signature in blue ink of the individual listed in number 22 is required. Also provide the title of the person signing the application. Include the city, state, and date where and when the application was signed. Print the name of the individual signing the application.

✓ **Did you remember to enclose (as applicable):**

- ❑ Copy of Driver's License or Identification card
- ❑ Copy of Social Security Card
- ❑ Copy of Tax Identification Number verification
- ❑ Copy of the CLIA Certificate
- ❑ Copy of License(s)
- ❑ Copy of the Fictitious Name Permit